Traumatic Stress and Trauma Counselling: Some Post-Tsunami Reflections from a Buddhist Perspective

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ABSTRACT

This paper discusses the psychological aspects of traumatic experiences and how traumatized individuals are helped with therapy/counselling. The conventional approach to understanding trauma reactions is summarized. The issue of the relevance of culture, including religion, is considered. The paper then focuses on the tsunami disaster, which occurred in South East and South Asia in December 2004. This event left thousands of people highly traumatized, and many were also bereaved. The paper describes the nature of the psychological reactions of the tsunami survivors in Sri Lanka. A trauma counselling training programme that has been undertaken is also briefly described. In the final part of the paper, the relevance of Buddhist ideas and practices to this field is considered.

Introduction

The term 'traumatic experience' can be defined in various ways, but it is generally agreed that it refers to an event that involves severe injury or threat to the person. A traumatic event also involves intense fear, including sometimes the fear of death. This experience may either be a direct personal one, or it could be vicarious, such as witnessing someone else being brutally murdered or attacked.

Various kinds of traumatic events have been studied and reported in the literature of psychology and psychiatry. These include: natural disasters, non-natural disasters such as industrial accidents, war and other armed conflicts, serious personal violence including rape and other forms of sexual assault, torture and road traffic accidents. A traumatized person may develop psychological difficulties, sometimes of a serious nature. The adverse psychological reactions to traumatic experiences have been recognized for a long time. It is said that a German physician named Eulenberg introduced the concept of psychic trauma in 1878, as a designation for the reaction of outcry and fear following extreme shock (Kleber, Brom & Defares, 1992). This was in the wake of the interest in what was called 'Erichsen's disease'. According to Keiser (1968), Erichsen had drawn attention to a condition which occurred following railway accidents. Erichsen had described this as assuming the form of traumatic hysteria, neurasthenia, hypochondriasis or melancholia, and attributed them to a concussion of the spine resulting from the accident. It was therefore also labelled as 'railway spine' (Keiser, 1968; Trimble, 1981). Much debate took place about the causes of the emotional responses to such accidents. In 1883, a British surgeon named Page drew a clear distinction between physical injuries and symptoms of a psychological nature, and introduced the concept of 'nervous shock' to refer to the latter (Trimble, 1981).

The early history of this concept is marked by the debate between those who favoured a neurological explanation and those who assumed psychological mechanisms. Freud and Breuer also wrote about the psychological effects of traumatic experiences, taking the view that strong emotions associated with traumatic events were often suppressed, leading to the subsequent development of symptoms linked to the trauma (Breuer & Freud, 1955). These early views and debates are discussed by several authors, including Kleber et al (1992) and Trimble (1981).

The experiences of soldiers in World War I provided fertile ground for those interested in this area. According the Keiser (1968), Mott had proposed the term 'shell shock' as a substitute for traumatic neurosis, previously introduced by a physician, Oppenheim ('Schreck Neurose' in German). Mott believed that the effects seen were caused by physical events – specifically, brain damage caused by a displacement of air, an overdose of carbon monoxide, and flying shrapnel. However, during the war, it became clear that many soldiers who had not personally experienced shell fire also displayed shell shock. Also, the affected soldiers would recover when removed from the trenches. By the end of World War I, the importance of psychological factors and mechanisms in this syndrome had become widely accepted. The work of Kardiner with veterans of the war represents the conceptual developments in the period between the two wars (Kardiner, 1941). In Kardiner's view, trauma was an alteration of the individual's usual environment in which his habitual adaptive strategies no longer proved adequate. The failure of adaptation led to symptoms. Kardiner observed certain constant symptoms in the war veterans. These included: fixation on the traumatic experience; repeated nightmares; irritability; exaggerated reactions to sudden noises; proneness to explosive aggressive behaviours; and a reduction of the general level of functioning, including intellectual functioning. There was also loss of interest in activities, low self-confidence, and dread of being annihilated.

After World War II, work on trauma-induced stress has flourished, with a variety of subject groups. These have included, among others, the following: concentration camp survivors; survivors of the atomic bombing in Japan; survivors of natural disasters; veterans of World War II; Vietnam War veterans in the United States; Israeli soldiers; and victims of personal violence, including rape (for a brief review and references see de Silva, 1999). This large body of work has thrown considerable light on human reactions to traumatic experiences of all sorts. It has highlighted for example the fact that, while some developed psychological symptoms immediately, some others became symptomatic only after a period of time. It has also highlighted two main aspects of the psychological sequelae of trauma: the tendency to re-experience the anxiety of the event in certain ways; and the tendency to numb, withdraw and avoid.

Post-Traumatic Stress Disorder

The formal recognition that traumatic experiences can lead to a cluster of psychological symptoms which could profitably be identified as a syndrome came in 1980, when the American Psychiatric Association included post-traumatic stress disorder (PTSD) as a diagnostic category in the third edition of the *Diagnostic and Statistical Manual* (DSM-III) in 1980 (APA, 1980). The work on traumatic experiences and their aftermath over the preceding decades formed the basis of this diagnosis and its criteria. The recognition of PTSD as a diagnostic category also acted as a facilitator and impetus for investigators to do further work on a variety of trauma-affected subject groups. The growth of studies and publications in this area in the post-1980 period bears testimony to this. Predictably, the growing body of empirical work on PTSD also led to the refinement of the conceptualization of the disorder. The developments in the thinking about, and understanding of, the effects of trauma have, in turn, led to the diagnostic criteria being re-drawn in the 1987 revised version of the DSM-III (DSM-III-R; APA, 1987), in the fourth edition of the manual (DSM-IV; APA, 1994), and in the tenth edition of the *International Classification of Diseases* (ICD-10; World Health Organization, 1992).

It will be useful to note, at this point, the diagnostic criteria for PTSD in the DSM-IV. These are as follows:

A. The person has been exposed to a traumatic event in which both of the following were present:

(1).the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; (2) the person's response involved intense fear, helplessness, or horror (**Note:** In children, this may be expressed instead by disorganized or agitated behaviour).

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions (**Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed); (2) recurrent distressing dreams of the event (**Note:** In children, there may be frightening dreams without recognizable content); (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated) (**Note:** In young children, trauma-specific re-enactment may occur); (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma; (2) efforts to avoid activities, places, or people that arouse recollections of the trauma; (3) inability to recall an important aspect of the trauma; (4) markedly diminished interest or participation in significant activities; (5) feeling of detachment or estrangement from others; (6) restricted range of affect (e.g. unable to have loving feelings); (7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep; (2) irritability or outbursts of anger; (3) difficulty concentrating; (4) hypervigilance; (5) exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social occupational or other important areas of functioning.

Specify if: **Acute:** if duration of symptoms is less than 3 months, or **Chronic:** if duration of symptoms is 3 months or more.

Specify if: **With delayed onset:** if onset of symptoms is at least 6 months after the stressor.

Because PTSD is diagnosed on the basis of the relevant symptoms persisting over one month, the DSM-IV (1994) introduced another diagnostic category, Acute Stress Disorder (ASD), to accommodate serious stress reactions that occur in the early aftermath of a trauma. The constellation of symptoms need to occur within four weeks of the event, and to last for a minimum of two days and a maximum of four weeks, for this diagnosis to be made. When the disturbance lasts longer than the four week period, the ASD diagnosis gives way to the PTSD diagnosis. This transition from ASD to PTSD is, as can be imagined, very common.

Natural Disasters

It was noted earlier that there are several kinds of events that lead to traumatic stress reactions. Here we shall focus on natural disasters, the psychological effects of which have been studied in some detail. The Swiss physician Stierelin studied the effect of the large mining disaster of Courrieres in 1906, and the earthquake of Messina in 1909 (Kleber et al., 1992). William James (1911) recorded his observations on the effects of the San Francisco earthquake of 1906. More recently, several major disasters have been studied. The most famous is perhaps the Buffalo Creek disaster in West Virginia in 1972. Prolonged rainfall caused the collapse of a dam in a valley causing 125 deaths and enormous damage (e.g. Erikson, 1976). The survivors showed various psychological effects, including: fears and phobias, particularly regarding water and rain; depression; intrusive memories and images of the event; increased sweating; drinking; a change in eating habits; and loss of interest in sex, social activities and pastimes. Clear psychological effects were found to persist over two years after the event.

Many other natural disasters have been studied for their psychological effects, and there are reports from different parts of the world, Eastern as well as Western. For reasons of space, they will not be discussed here (see de Silva, 1999, for a review). It is, however, useful to dwell briefly on the Patrick and Patrick (1981) study of the cyclone that occurred in Eastern and North Central Sri Lanka in 1978. The authors studied the Batticaloa region, which was the most severely affected area. The number of deaths reported was 889. The authors conducted a hospital records review, a pilot study of a sample of survivors, and a main study which compared a cyclone affected village with a control village, with samples of 79 and 92 respectively. Seventy-seven per cent of the sample from the affected village (Paddirupu) showed psychological dysfunction, compared to only 4 per cent of the control sample (Thirukovil). Anxiety (84 %) and phobias (68 %) were the most commonly reported symptoms. Depression and suicidal ideation were also relatively high (41 %). In addition to this individual psychological morbidity, there was also clear social morbidity.

Culture and Trauma

There has been some discussion in the literature on the relevance of culture, including religion, to the understanding and management of traumatic reactions including PTSD (see de Silva, 1999; also de Vries, 1996). Is the vulnerability to psychological disturbances following a catastrophic event the same across different cultures? Are the predominant symptoms the same? Are there differences in how people in diverse cultures cope with their symptoms and difficulties? These questions cannot be ignored by professionals and others endeavouring to help traumatized individuals. Some discussion of these issues is in order.

Broadly speaking, the various parameters that go to make up an individual's identity all influence to some extent his/her reaction to a significant traumatic event. Social class, race, ethnicity, gender and religion are thus all relevant. The significance of these in this role is influenced, to a greater or lesser degree, by the assumptions and attitudes found in the individual's society and culture.

An equally important variable is the presence or absence, and the extent, of social support that a trauma victim has, after his/her experience. The support may come from family and friends, or from a wider network. There is empirical evidence that show the value of this support, as for example shown by Barrett & Mizes (1988) for Vietnam War veterans. Empirical work by Joseph in Britain (e.g. Joseph et al., 1992) highlights the importance of social support for trauma survivors. This support can contribute to a lowering of the probability of the individual developing full-blown PTSD, and also to the speed of recovery and adjustment. It has been said, in this context, that "social support is the individual's psychological experience of others' helpfulness rather than some objective or observable phenomenon" (McCann & Pearlman, 1990, p.119). It is certainly the case that the individual's perception of the support given is a critical factor. However, the ready availability of otherwise of a clear support system is a variable that can be objectively tested for its overall efficacy in helping trauma victims. As cultures differ markedly in the extent to which such support systems – such as the extended family – exist, it is an empirical question that can be investigated.

As for broad national, cultural and ethnic differences in the vulnerability to, and manifestation of, traumatic stress reactions, the available evidence is not extensive. Kulka et al. (1991) found ethnic differences among the American Vietnam War veterans. The group that were most affected were the Hispanics, with a rate about twice as high as that for Whites. An early report by Williams (1950) provides a fascinating study of Indian and British soldiers in World War II, in battles in Burma against the Japanese. Williams was a field psychiatrist to the 26th Indian Division in the Arakan from February 1944 to May 1945. He found that, among these soldiers, "psychiatric illness was proportionately two and a half times more frequent in all British than in all Indian troops" (Williams, 1950, p. 131). When a comparison was made for the troops who were actually fighting, the ratio rose to three and a half times to one. The British troops were vastly more affected by anxiety states than their Indian counterparts. Williams's report provides further details, and also offers various speculations about the differences he had observed. One interesting comment he makes is that the Indians showed far fewer anxiety states, because "to exhibit anxiety meant great loss of face" (p.165). So some of them terminated an anxiety-laden situation with a self-inflicted wound. In contrast, "British soldiers did not need to deny anxiety as fear was socially acceptable" (p.165). Williams (1950) also commented on other socio-cultural factors (e.g. extended family) that he considered relevant.

Some interesting data relevant to this issue have also been provided by Wardak (1993) working with Afghan war victims and refugees. Wardak (1993, p.36)) stated: "Certain symptoms reported by Afghans, such as severe dysphoria, sleep disturbances, and loss of appetite, are similar to those reported in Western countries. Other symptoms (e.g. crying spells, feeling of guilt, suicidal thoughts and acts) are largely inhibited by sociocultural factors. Men and young boys are not supposed to cry; this is believed to be appropriate only for girls and women". Wardak (1993) attributed the extremely low figures of suicidal ideation, let alone suicidal acts, in this traumatized population to the fact that Islam strongly prohibits the act of suicide and regards it as a criminal act.

While these papers are of interest, it is not possible to draw general conclusions from these findings and observations. The kind of empirical, up-to-date, information needed before any firm conclusions can be drawn about national differences in vulnerability to stress and in the manifestation of stress reactions, simply does not exist. It remains a challenging area to investigate, but one fraught with numerous methodological problems for the researcher.

It is relevant, at this point, to refer to the notion of 'shattered assumptions' that has been postulated by Janoff-Bulman (1992). According to Janoff-Bulman, the experience of a major trauma shatters the individual's assumptions about the universe and self. She proposes that there are three fundamental assumptions: (i) the world is benevolent; (ii) the world is meaningful; and (iii) the self is worthy. A major catastrophe can cause these assumptions to be shattered. One feels that the world is not safe, is not benevolent, and that one is not invulnerable. Part of the psychological reaction to a major trauma is this shattering on one's assumptions. Janoff-Bulman's views have clear implications for the role of culture in PTSD. The worldview, including the core assumptions, of an individual can be expected to be largely determined by the beliefs in his or her culture, including religion. The core assumptions identified by Janoff-Bulman (1992) are, at best, those of Western industrialized cultures. People of different cultures may have different core assumptions about the universe, life and oneself. Would their reactions to a trauma reflect these? This is a most interesting issue, and we shall return to it later.

A further issue related to the role of culture in PTSD is what is available, in a given cultural setting, to help the traumatized individual in the healing process. Wilson (1989) has provided an illuminating discussion of this. He points out that historically, in many cultures and societies, rituals were performed to welcome home those who went to war. This eased the return of the soldier to civilian life. An implication is that these rituals may contribute to the psychological well-being of the individuals concerned. Wilson cites the example of the Sweat Lodge purifications ritual (*inipi onikare)* of the Native Americans. It is a religious event of thanksgiving and forgiveness which is typically conducted by a 'medicine person' in the tribe. "It is regarded as a serious and sacred occasion in which spiritual insights, personal growth, and physical and emotional healing may take place. The process of purification is experienced on many levels of awareness,

including the physical, psychological, social and spiritual" (Wilson, 1989, p.44). He analyses the elements found in the Sweat Lodge ritual and goes on to examine how it may function as a form of treatment for PTSD. The elements of the Sweat Lodge ritual include extreme heat, sensory deprivation, singing, restricted mobility, self-disclosure, and a sense of collectiveness. These, Wilson argues, can bring about changes in the various symptoms and symptom clusters that are part of PTSD. It is well known that many tribes and cultures do have similar rituals and healing ceremonies, and some of them may be effective in helping trauma victims to re-integrate and heal. Wilson (1989) has reported on his experimental treatment programme for PTSD cases, where a number of elements. This was a six-day-long event, which utilized a number of treatment modalities. Sweat Lodge exercises were included at the end of each day. The results were impressive. There was significant improvement in many symptoms, including a reduction of negative emotions.

Religion and Coping

Religion is a major aspect of culture, and the part religion plays in the aftermath of a disaster or other catastrophe is a topic that needs some discussion. Difficult experiences require coping, and successful coping reduces the likelihood of negative consequences for the person's psychological well-being (Lazarus, 1966; Snyder and Dinoff, 1999). A person's religion can help in the coping process, and many people naturally turn to their religion in difficult circumstances. A religion may offer practices and rituals to help adherents to cope. These consist of individual acts as well as jointly performed group activities. Religion also helps in the coping process by giving the person ways of construing the event or disaster, of making sense of what has happened. It also tends to influence what ends or outcomes the person seeks and pursues.

There has been some empirical work on religious coping in recent years. This work has been reviewed by Harrison et al. (2001). These authors have suggested that clinicians should enquire from their patients/clients about if and when they use their religious beliefs and practices to cope. This helps the clinician to gain an understanding of how the patient/client gives meaning to the problem or illness. The clinician's interest in this is also said to enhance the therapeutic relationship. In the actual practice of therapy or counselling, the client's own coping strategies can profitably be incorporated into the overall intervention, so long as these do not conflict with the desired treatment goals. They may be used or encouraged along with other, more conventional, treatment strategies. In some cases they may be the only ones needed.

The Tsunami in Sri Lanka

We shall now turn to the impact of the tsunami on those who were exposed to this unprecedented natural disaster in Sri Lanka.

The tsunami occurred on the 26th of December 2004, an unexpected, monumental disaster. The Asian lands affected were Indonesia, Malaysia, Thailand, Burma, India, Bangladesh, Sri Lanka and Maldives. Indonesia, closest to the under-sea events which caused the tsunami, was the worst affected. Sri Lanka was the next worst affected. The official records note 31, 229 people dead, 4100 missing and 516, 150 displaced in the island (Miller, 2005). The Eastern, Southern and parts of the Western coastal areas were affected. Many families lost several members, a large number of children perished, and an even larger number of children were orphaned.

The vast impact of the Tsunami was evident from the outset. The survivors had gone through a hugely traumatic experience, many suffering injuries and many others having nearly drowned. To complicate matters, many of the survivors had lost family members; in many cases they had seen their family members perishing, despite their efforts to save them. Many mothers had their little children plucked away from their arms by the relentless waves. In the case of many who were bereaved, the bodies of the lost ones could not be found, or – in some cases – the corpses had been buried in mass graves before the family could see them. In addition, many survivors had their homes destroyed or badly damaged, and material possessions and means of livelihood, such as boats, were lost or irreparably damaged.

Much has been written about the tsunami in Sri Lanka, and it is unnecessary to go over that material here. What this section of the paper will concentrate on is the psychological impact of the tsunami, and the work that the author and his colleagues have been involved in.

The UK – Sri Lanka Trauma Group (UKSLTG) was formed in 1996, by a group of mental health professionals including the author. Most, but not all, of the members are expatriate Sri Lankans living in the UK. The organization was formed with the aim of helping with the psychological work related to the trauma of the armed conflict in Sri Lanka. Since the tsunami, the UKSLTG has been involved in training professionals, including doctors, psychologists, nurses and teachers, as well as volunteers, in trauma counselling. The focus has been on dealing with trauma reactions, including PTSD, and with grief reactions. The reports from the groups of trainees working directly with survivors have made it clear that the majority of survivors have been psychologically affected. In training workshops conducted in Colombo, Kalmunai, Galle, Hambantota, Negombo and other places, participants reported the psychological difficulties that the survivors displayed. These included clusters of symptoms well described in the trauma literature. Interestingly, they also reported that many of the survivors complained of numerous physical symptoms, such as aches and pains,

for which there was no physical basis. Some, they said, complained of these as their primary concern, and would talk about psychological symptoms only upon enquiry. In addition, as mentioned above, many were reported to have complex grief reactions, and in many, strong feelings of guilt that they had not done enough to save those who perished. In most cases the survivors had to contend with lack of housing and very limited basic amenities, and loss of livelihood. The loss of homes and the destruction of villages had led to displacement which added to the breakdown of social networks. These factors made their psychological distress worse.

The training focussed on several aspects. One was the need to develop a supportive, sympathetic relationship. In the early stages this was more relevant than specific therapeutic techniques. The need to provide, or arrange for the provision of, essential information about how to access material assistance from the state and the other agencies was also emphasised. Another key area was that of assessment of symptoms and overall level of distress. The counselling/therapeutic skills that formed the core training consisted of techniques coming under the umbrella of cognitive-behavioural therapy, for the efficacy of which there is very good evidence (Ehlers et al., 2005; Livanou, 2001). The principles included those of planned and detailed recall of the experience, and of behavioural work on exposure to avoided stimuli and situations. The need for, and ways of, dealing with unhelpful and maladaptive cognitions was also emphasized in the training. This included work to help modify negative appraisals of the trauma sequelae. The importance of helping/enabling the person to 'reclaim' his/her life, in the sense of going back to work/routine/school/pastimes as soon as possible, was also stressed. Special consideration was given to helping survivors to deal with grief and loss. For working with children the value of loss-related activities in the form of play was also discussed.

While much of the effective work in the modern trauma treatment literature is individual (i.e., one to one therapy) the training workshops also dealt with the role of group work. Many trainees reported their inability to deal with all those who needed help on an individual basis, and the group format had to be considered.

The training events have been conducted through collaboration with various local organizations, including the Ministry of Health, National Institute of Education, Sri Lanka Medical Association, Basic Needs (NGO), the Forum for Research and Development and others. Some of the training has been done jointly with the Northern Ireland Centre for Trauma and Transformation; two professionals from this specialist centre worked with UKSLTG members in November 2005.

The UKSLTG plans to open resource centres in Colombo and three provincial towns to facilitate their work. It is intended that these centres will be able to ensure regular supervision for the trained counsellors and to provide

further training. Plans are also afoot to undertake systematic evaluation of the work done by the counsellors in the field. A manual written by Professor William Yule of the University of London will be used as the basis for the therapy package to be evaluated.

A Buddhist Perspective

As can be seen from the brief account given above, the focus in our formal training events was on established theoretical accounts and evidence-based therapeutic strategies. However, in informal discussion with the trainees and others, the issues of the relevance and of a Buddhist perspective, and of a possible Buddhist approach, were raised. A factor that gave impetus to this was the international conference 'A Buddhist Response to the Tsunami' that was held in Colombo in March 2005. The following paragraphs will briefly focus on these issues and explore some of the possibilities.

Numerous Buddhist monks in the affected areas provided immediate help and support to the survivors of the tsunami. People made homeless were taken into temple compounds, and given food and shelter. This was irrespective of whether they were Buddhists or not. This spontaneous response of Buddhist monks has been commented on by several observers and reporters. For example, Cardinal Cormac Murphy-O'Connor, the Roman Catholic prelate of Britain, who visited Sri Lanka in December 2005 wrote in the *Sunday Telegraph* (London) of 01.01.2006: "There is no doubt that in the weeks after the tsunami, communities came together in Sri Lanka in a remarkable way. A group of Buddhist monks...spoke movingly to me in Colombo of how 'we all became one and helped each other'. Buddhist temples opened their doors, and enmities dissolved in the rush to provide for basic needs. 'We all came together', one monk told me, 'and we saw only humanity' ". It was a natural reaction to the suffering of fellow human beings, driven by compassion. Following the initial help and support, many Buddhist monks and Buddhist organizations have been involved in further work, providing material help as well as psychological support and counselling.

While there has been no systematic evaluation of the relevance of Buddhist ideas and strategies to the management of trauma reactions following the tsunami, some general considerations are in order.

We noted above the notion of shattered assumptions, proposed by Janoff-Bulman (1992). What would be the position of a Buddhist population, both at an individual and social level, to a catastrophic natural disaster? The key concept of impermanence (*anicca*) would obviously be a factor in their reaction, and indeed there in a good deal of evidence that many tsunami survivors, including those bereaved, saw the tragedy as yet another, if dramatic, example of *anicca* (the notion that everything is impermanent; one of the three signata of the phenomenal world according to Buddhist teaching, the others being unsatisfactoriness or 'suffering', and the absence of an abiding self or 'soul'). There is also the

concept of *kamma*, the notion that one reaps the consequences of one's actions, in which some have evidently found at least a partial explanation of the events and losses. Does this mean that the basic assumptions about life and the universe of a Buddhist make him/her more capable of accepting, and dealing with, a catastrophic experience, than someone whose assumptions are those noted by Janoff-Bulman (1992)? More specifically, because of the attitudes and beliefs mentioned above, are Buddhist survivors less likely to develop psychological disturbances such as PTSD? Systemic and careful study is needed before firm conclusions can be drawn. What we do know, from our involvement in counsellor training, is that many Buddhists who were exposed to the tsunami experience did develop many of the common psychological symptoms of PTSD such as intrusive thoughts and images, anxiety, avoidance, poor sleep, poor concentration *etc*. Many also suffered strong guilt. Those who were bereaved showed significant grief reactions. Some developed signs of depression, a well-known co-morbid condition in those with traumatic stress. Empirical studies assessing the extent and severity of these common post-trauma symptoms in large samples of Buddhist survivors, in comparison to groups from other religious traditions, will no doubt throw light on this issue. No such studies are currently available.

The next issue is whether, in the therapy/counselling of trauma survivors, specific Buddhist ideas and notions can fruitfully be used. It was noted in an earlier paragraph that many people tend to resort to religious coping, and also that clinicians can profitably take note of this. The Buddhist notion of *anicca* noted above is clearly a factor which can play a part in the cognitive work that forms part of cognitive-behavioural therapy. In the case of most Buddhist clients it would be a matter of providing support for their own views on life and nature. While accepting the loss, the person must also be encouraged to reclaim and rebuild his/her life. The concepts of *viriya* (energy, vigour) and *vāyāma* (effort, endeavour) are relevant here. These can underpin the necessary behavioural steps that cognitive-behavioural work requires. *Anicca* was never meant in Buddhism to be a reason for inaction or lack of effort. It was an acceptance of reality, which did not negate effort. Nor does the Buddhist notion of *kamma* promote inaction and helplessness; in fact *kamma* is only one of five laws governing living organisms. Further, the Buddhist concept of *kamma* does not signify a static state of predetermination; rather, it refers to a dynamic process of volitional deeds modifying results (see Guruge, 1999).

The concept of *karunā* (compassion; one of the four sublime states) also has obvious relevance. The compassionate acts of Buddhist monks in the immediate aftermath of the tsunami were noted above. The attitude of the therapist/counsellor could be expected to benefit from, and be enhanced by, genuine compassion. Equally, the survivor's own compassion may be directed, when and where possible, towards helping others. Involvement in helping others can enhance one's own psychological well-being. Developing a compassionate attitude towards oneself can also be useful in dealing with guilt, shame and self-blame, all of which are often part of traumatic reactions. It is worth noting, at this

point, that some present-day psychologists and other health professionals have recognized the value of compassion in psychological therapy. Lee (2005), for example, has provided an account of a model to develop a compassionate mind in the context of cognitive therapy. This is an area where much empirical work is likely to be undertaken in the coming years.

There is a growing literature on the value of meditation, especially mindfulness meditation, for clinical problems. The work of Jon Kabat-Zinn, John Teasdale and others (e.g. Kabat-Zinn et al, 1992; Segal, Williams and Teasdale, 2002; see Baer, 2003, for a review) has already made an impact on psychological practice. The development of the ability to be mindful of one's emotions, cognitions and bodily sensations as they arise, has a clear beneficial effect, and has been shown to be valuable in the treatment of a variety of problems including depression, anxiety and pain. It should be equally applicable to trauma-related cognitions, including intrusive images and memories, and trauma-related emotions. There is already some interesting preliminary work in the literature along these lines (e.g. Miller, 2005; Urbanowski & Miller, 2005).

The advantage of using and encouraging these strategies in Buddhists is that they are very much part of their cultural-religious tradition. Thus they will not be seen as 'alien' by the client, and compliance with therapeutic advice is likely to be enhanced (de Silva, 1984).

Does this mean that the established cognitive-behavioural treatment strategies for PTSD, for which there is a very good evidence base (see Livanou, 2001) should be abandoned in favour of the Buddhist strategies, in helping Buddhists who have been traumatized? The answer is 'No'. The need is to have in one's repertoire a range of strategies, including the conventional ones as well as the Buddhist ones. In any case Buddhist strategies are not incompatible with the cognitive-behavioural approach; indeed some of them bear close resemblance to those used in the latter (see de Silva, 1984; Evans, 2006; Mikulas, 1983). After careful assessment of the predominant symptoms of each client, and the client's overall mental state, the counsellor/therapist may suggest certain techniques, drawing from both traditions. As noted above, some of the Buddhist elements can be valuable in dealing with cognitions, others in dealing with behaviours. Combining Western and Buddhist strategies is already practised in psychological therapy and counselling (e.g. Segal et al., 2002; Kabat-Zinn et al., 1992), and this is not confined to work with Buddhist clients. There is, however, a need to evaluate the efficacy of strategies, singly and/or in combination as the case may be. It is such evaluation that ultimately establishes which approach, which strategy, works for which problem, for which type of person.

Finally, a brief not is necessary about the shared, or group, practices used by Buddhists. Protective chanting (*paritta*) is widely used as a means of giving protection and enhancing well-being. Certain discourses from the Buddhist Canon are chanted, usually by the monks, in this way on various occasions (see Dhammavihari, 2003, for a discussion of this). The giving of alms (*dāna*) is commonly practised, especially following someone's death, after seven days,

three months, and one year. These are both traditional group activities, involving the family, extended family, and community. These group practices have been engaged in by the Buddhists affected by the tsunami, and by various Buddhist organizations in the country, following the disaster. On the first anniversary of the event, there were community-based as well as family-centred alms giving ceremonies and *paritta* chanting events throughout the affected areas and beyond. These traditional activities can be seen as culturally accepted coping methods in the Buddhist tradition of Sri Lanka. They not only bring solace to the traumatized or bereaved individual; they also have the effect of fostering social re-integration after the massive disruptions caused by a catastrophe such as the tsunami.

The tsunami experience in Sri Lanka has provided the impetus for considering Buddhist ideas and strategies in understanding traumatic stress reactions and in helping those needing counselling to overcome their trauma-related symptoms. It is hoped that systematic work towards the development of a comprehensive Buddhist perspective on these matters will now be undertaken.

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